

# The Calgary Participator

A Family Therapy Newsletter  
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## Index

Greetings Carol Liske	page 1
Parry Looks at the Books Alan Parry	page 2
DSM Criticisms Karl Tomm	page 2
Participator Profile Maureen Leahey	page 3
Violence, Sex, and Therapeutic Healing Gary Sanders	page 8
Sexplay Gary Sanders	page 11
Story-Connecting: What Therapy is all About Alan Parry	page 12
From Narcissism to Narcissus: The Journey from Bondage Carol Liske	page 15
Participants' Conference	page 14
Subscription Information	page 16

## Greetings!

Welcome to your first journey into *The Calgary Participator: A Family Therapy Newsletter!* The idea for this new adventure was generated at the final meeting of the 1990 *Participants' Conference* as a way to represent and share the knowledge of regional family therapists. The hope is that this will truly become a "participators" newsletter and that various individuals and agencies will not only contribute articles or take on regular features but may even take on the responsibility of producing an entire issue--perhaps with a specific theme. The concept to be fostered is that everyone's contributions are important and that *The Calgary Participator* can help provide a regional forum for the fullest expression of your ideas. All submissions are welcome!

This issue--as you can see--has been primarily conceived by the Family Therapy Program staff. Although this was not our preference--we would like to have had many contributors from other agencies--it ensures a start to the newsletter. We hope to develop three feature columns. They are: "Sexplay" by Gary Sanders who hopes not only to elucidate about FT sexual issues but to also lighten the burden with a touch of humour; "Parry Looks at the Books" by Alan Parry who has chosen to review postmodern fiction as he believes that there are several sources of academic book reviews but few representing the MFT-relevance of contemporary fiction; and "Participator Profile" which will focus on the ideas and professional development of individual family therapists within our professional community in hopes of improving professional community connection and collaboration.

Also, incorporated in this issue are a

brief overview of Karl Tomm's ideas on criticisms (by type) of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-II, DSM-III, DSM-III-R). In addition, Gary Sanders has written a thoughtful article about a therapy with a young female victim of sexual abuse entitled "Violence, Sex and Therapeutic Healing" and Alan Parry offers his synergistic ideas about therapeutic story-connecting ("Story-Connecting: What Therapy is All About!"). Finally, Carol Liske represents some reconceptualizing about the *story* of "narcissism" following having been challenged to see a paradoxical view to conventional usage--"From Narcissism to Narcissus: The Journey from Bondage?"

We encourage comments, rebuttals, and so on about these articles as well as suggestions for improving our newsletter format and content. We look forward to your submissions and/or interest in helping with or taking responsibility for a whole *The Calgary Participator* issue. In keeping with the tradition of the *Participants' Conference*, the success of *The Calgary Participator* will depend on your willingness to be involved. Please contact Carol Liske, Gary Sanders, or Alan Parry at the Family Therapy Program, University of Calgary Medical Clinic, 3350 Hospital Drive N. W., Calgary, Alberta, Canada, T2N 4N1 (Phone 403-220-3300).

In the meantime, we thank you for your contribution as a reader and may you profit from and enjoy this first edition of *The Calgary Participator*.

Carol Liske, Ph.D.

Alan Parry, Ph.D.

Gary Sanders, M.D.

Editorial Committee



# Parry Looks at the Books



Alan Parry  
Family Therapy Program  
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## One Hundred Years of Solitude: A Review

John Barth, himself no mean post-modern writer, has termed this book the best novel written in the second half of the twentieth century. It might be referred to as the showpiece work of this Nobel laureate as well as the most renowned work of the Latin American magical realists. The dominant characteristic of these writers has been the creation of characters and situations so much larger than life that they seize the imagination and, in so doing, break through all conventional boundaries between so-called reality and so-called fantasy. Magical realism is preeminently representative of the post-modern sensibility in that, liberated from the constraints of what William Blake scornfully dismissed as "single vision and Newton's sleep," the imagination is brought in from its marginalized position in *serious* Western thought to serve as the quality that lends lives and events a mythic dimension. Here, myth is created, decidedly not of the deeds of gods and heroes but of more or less ordinary people who, in V.S. Pritchett's word, live inordinate lives. It is in the very extravagance and exaggeration with which they live that gives them their mythic quality. In a world, then, that lacks any universal vantage point, any "single vision," or that lacks the kinds of heroes that serve as models of how to live, the larger-than-life characters who enchant us in Marquez's masterpiece beckon us simply to live as fully and as imaginatively as we dare.

*One Hundred Years of Solitude* is the wondrous tale of six generations of the Buendia families living under the ever-watchful eye of the ageless matriarch Ur-

sula in the mythic town of Macondo, in Colombia. From the celebrated opening sentence--"Many years later, as he faced the firing squad, Colonel Aureliano Buendia was to remember that distant afternoon when his father took him to discover ice"--to the final moral that "races condemned to one hundred years of solitude did not have a second opportunity on the earth"--we know that we have descended into the domain of myth. But it is a mythic domain that is as alive and vibrant and earthy as life gets. Aureliano Buendia so enjoys his sexual appetite that his pleasure becomes contagious and even his livestock catch his fever. Remedios the Beauty is so extravagantly beautiful that men cannot keep their eyes from her. She, however, is so indifferent to her beauty and so utterly lacking in vanity that she decides to limit herself to the wearing of only a coarse body-length cassock. Combing and arranging her hair is also unnecessarily complicating so she cuts it off. Yet, suspecting that there is nothing but her nakedness underneath the cassock and, finding the simplicity and perfection of her shaved skull ravishing, the men of Macondo are even more

maddened by her beauty. Never mind, she remains perplexed and innocent in the face of all this and, in the end, in her entirely unselfconscious purity she is suddenly lifted up, levitates heavenward, and is never seen again.

*'Don't you feel well?' she asked her...*

*'Quite the opposite,' she said, 'I never felt better.'*

*She had just finished saying this when Fernanda felt a delicate wind of light pull the sheets out of her hands and open them up wide. Amaranta felt a mysterious trembling in the lace on her petticoats and she tried to grasp the sheet so that she would not fall down at the instant in which Remedios the Beauty began to rise. Ursula, almost blind at the time, was the only person who was sufficiently calm to identify the nature of that determined wind and she left the sheets to the mercy of the light as she watched Remedios the Beauty waving goodbye in the midst of the flapping sheets that rose up with her, abandoning with her the environment of beetles and dahlias and passing*

*continued on page 14*

## DSM (II, III, IIIR) Criticisms

Karl Tomm  
Family Therapy Program  
The University of Calgary

*Editors note. The following DSM (II, III, IIIR) criticisms were presented at the 1990 Participant's Conference to aid in the assessment of various critical perspectives that can be assumed in relation to the Diagnostic and Statistical Manual of the American Psychiatric Association. It is being presented here for more leisurely perusal in a simple outline format to maintain the parsimony of the ideas—without elaboration.*

### Empirical Criticisms

1. The nature of the disorder, its diagnostic criteria, and the boundaries of categories are determined in APA committees, not by the phenomena being described.

2. DSM is unable to encompass many clinical situations (i.e., the "V" codes are inadequate).

3. There is no provision for interpersonal, familial, cultural, or institutional "diagnoses."

### Political Criticisms

1. Constitutive "power" in defining the nature of persons can easily be abused.

2. In whose interest is it to label (professionals; patients; other parties such as family members, insurance agents, government; etc.)?

3. DSM promotes the "medical model" and psychiatric supremacy in the mental health field.

4. Gender bias maybe institutionalized (i.e., "PMS" is being considered for DSM-IV), as a heterosexuality bias (i.e., "homosexuality" was included in DSM-II) with reification of traditional stereotyping.

### Humanitarian Criticisms

1. Persons are dehumanized by transforming them into subjects under the scientific "gaze."

2. Persons are pathologized through



labeling, totalizing, and segregating.

3. DSM promotes an "orientation towards inadequacies" by attending to tragedies and personal failures rather than an "orientation towards solutions" with attention to *resources* and *competence*.

### Pragmatic Criticisms

1. There is an overemphasis on the general syndrome and a de-emphasis with respect to the specific experiences and personal context of the client.

2. DSM promotes a static rather than a dynamic perspective by emphasizing permanent traits rather than transient states.

3. DSM promotes blindness with respect to the interpersonal and cultural factors that contribute to mental health problems.

4. DSM is seldom useful in the determination of a specific treatment plan.

### Ontological Criticisms

1. The basic assumption about the nature of mental phenomena seems problematic (i.e., that mental disorders are "in the person" vs. "in the interaction between the person and the context" vs. "in the coordination of interaction among persons").

### Ironic Criticisms

1. DSM fails to include the diagnosis of the "DSM syndrome"—a spiritual psychosis characterized by a compulsive desire to objectify persons and to label them according to predetermined psychiatric categories.

2. These "victims" of modern psychiatric ideology give priority to knowledge about precise descriptions—over knowledge about healing interactions—as manifest by obsessive preoccupation with pejorative adjectives, inclusion and exclusion criteria, etc. 🍏



"Hank! You're reflecting!"

## Participator Profile

an interview with

Dr. Maureen Leachey

**Participator.** Could you tell me a bit about your biographical background?

**Maureen.** Well, my background is in Nursing. I did my undergraduate degree in Nursing at Cornell and worked for several years as a Community Health Nurse in New York before coming to Calgary in 1972. Originally, when I first came to Calgary I worked for Calgary Health Services and then started working at what was called the Ambulatory Care Centre at the Faculty of Medicine. I worked there in Pediatrics with Dr. Bob McArthur who is the head of Pediatrics now and set up a pediatric diabetic program. Dr. Karl Tomm, a Family Psychiatrist, had just come to Calgary and was interested in developing a Family Therapy Program. Pediatricians would refer patients to Karl and I would go over with the family to meet him. Karl would say "Would you like to sit in on the meeting?" and one thing lead to another. I then worked half time in family therapy and half time in pediatrics for two years.

After that, I decided to go for my masters so that I would not be doing family therapy by "the seat of my pants." I did a masters in Medical Science. Actually, it was more of a masters in Family Therapy with Karl Tomm as my supervisor and me the only one in that specific masters program. I then worked at the Family Therapy Program for awhile after this to increase my clinical skills. Between 1978 and 1981, I had an appointment in the Faculty of Medicine in the Departments of Psychiatry and Pediatrics. This was when I worked at Alberta Children's Hospital with Dr. Tim Yates starting the Mental Health Program. Fol-

lowing this, I went back for my doctorate in educational psychology. Since 1984, I have been at the Holy Cross Hospital in Calgary. Currently, I direct one of the

outpatient teams in Mental Health and I also direct the Family Therapy Institute.

**Participator.**

You've very much come from a broad base of knowledge about family life.

**Maureen.** Yes.

I didn't come to family therapy just from the family therapy field but I think that most people have not come just from the field.

**Participator.**

What differences do you think that will make for the

FT field, in the future, if family therapists do come directly into the field early. Given that sometimes a breadth of knowledge can be a great contribution to doing the work?

**Maureen.** Well, I think there are pros and cons because I think people coming out of a masters in Marriage and Family Therapy most likely will have an easier time understanding the systems theoretical perspective because they will not have to unlearn some of the intrapsychic material. What, potentially, they can lack is an appreciation of the other disciplines or of the biological piece influencing interaction. I remember that the Milan Team, Boscolo, and Cecchin, when they first came to Calgary, talked about requiring that their trainees had to have two years of psychodynamic training, or at least training in other forms of psychotherapy before they took them into their own training program.

**Participator.** An interesting dilemma. I've been experiencing in my own work a feeling that it would be advantageous for me to develop a stronger psychodynamic background.

**Maureen.** Well, I think it has its



pros and cons. That is going to be one of the issues in the field as more people graduate as "pure" family therapists. We don't have enough of them yet to see because there are not that many FT training programs. There has been only one in Canada, the Guelph Program, that produces graduates with a masters in Marriage and Family Therapy. There also is one other program that is just starting out at Canadian Union College in Lacombe offering a masters in Marriage and Family Therapy. Those are the only two in Canada. In the States there are, I don't know the numbers, but probably not more than ten.

**Participant.** Will FT programs have to restructure some of their thinking about what course work they will offer to prepare a family therapist to do his/her job?

**Maureen.** Yes, I sit on the Commission on Accreditation for Marriage and Family Therapy Education and one of the things that we have looked at are the standards for different programs in Marriage and Family Therapy. The revised standards adopted in 1988 reflect some of these changes.

**Participant.** Have you envisioned the development in the field of FT in the province of Alberta as a generic profession rather than a sub profession representing several different professional fields?

**Maureen.** Well, I've thought about that and I think its a big controversy in the field in general, not just an issue in Alberta. Its too early to come down on either side of what I would call a generic profession verses a specialization within a profession. I don't use the term "sub profession". In Canada, we just have too few training programs to be able to say how the field will progress. Right now, we are probably ten years behind the U.S. in terms of training programs. What happened in the States is that in 1978 the Department of Education recognized Marriage and Family Therapy as a fifth mental health discipline. Prior to that, FT was seen as a specialization within other disciplines (eg. Psychology, Social Work, etc.). But when the Department of Education recognized it as having a distinct body of knowledge, this influenced the field tremendously because then people started to see family therapy as a distinct discipline. It was then that we had

the emergence of schools offering a masters or doctorate solely in marriage and family therapy, like for example, Brigham Young University, Purdue or Virginia Tech.

There is a controversy right now in the field about who should define themselves as family therapists. One of the counselling associations in the U.S. is currently developing standards for Marriage and Family Therapy within their profession and they have started an international FT association. They are suggesting that some counsellors who have completed a few courses and practicum in MFT would be considered a Marriage and Family Therapist. Their standards for training are quite different from those adopted by AAMFT. So, there is a wide range of people who can call themselves Marriage and Family Therapists.

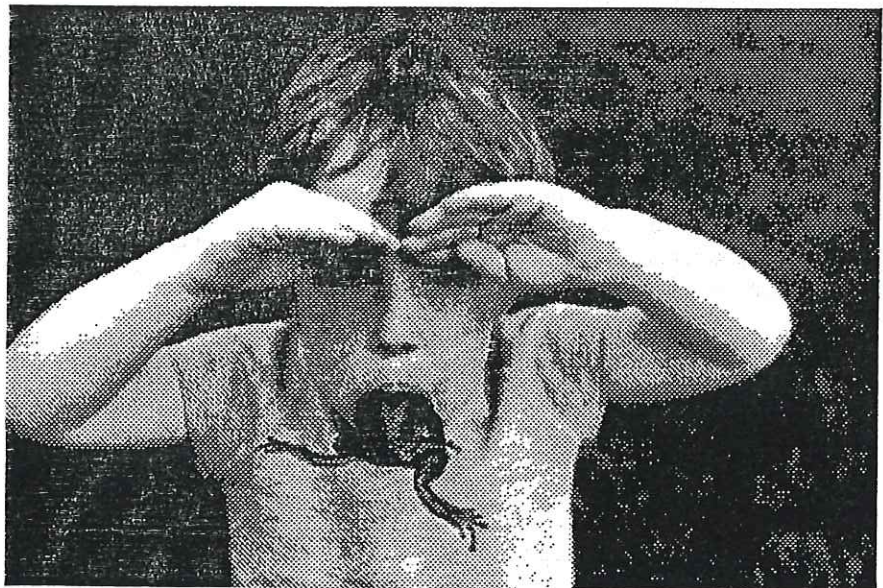
**Participant.** Would you foresee there will come a time when it will be one way or another or do you think that we could live with these two ways of accessing the profession for a long time?

**Maureen.** I think we'll live with it for a long time. There will be some "purists" and others who have a specialization from one of the other disciplines. I believe it is an ongoing issue.

**Participant.** What ideas do you have about implementing standards of FT practice in Alberta?

**Maureen.** I do have a couple of different ideas. First, is that I think training programs should really endeavor to get accreditation so that there would be some standards of practice and of training. What accreditation does is it helps to standardize training so that if someone takes training in an accredited program, then that person's certificate or degree has more "portability" and transferability. Our Family Therapy Training Program at the Holy Cross Hospital is currently applying for Candidacy Status with the Commission on Accreditation. This is the status accorded to those programs that have not yet graduated a class. Our program has only been operating a Certificate Track since Fall 1989 and thus we have not graduated a class. Our program has existed, however, since 1985. I am hopeful that we could get Candidacy Status by next year. The process does take a while because there is a site visit and a review of the program by the Commission. Accreditation is something that we have been looking toward over the past several years and we are quite excited about it.

A second way of implementing standards in Alberta is through legislation. I am aware that the Alberta Association for Marriage and Family Therapy has formed a legislative committee to explore the development of licensure, reg-



Parentthesizing objectivity: boy and frog appear to structurally couple



istration, or certification for Marriage and Family Therapists in the province. This process will take several years and there will be lots of issues to contend with but I think there is nothing that gives you more standardization than if people can say they are licensed. At least the public then knows the minimum qualifications for competence.

Another thing I believe is that agencies and hospitals can promote standardization by using AAMFT clinical membership as a standard. For example, in job descriptions they can start to say that a requirement for the position is that a person would have AAMFT clinical membership.

I think it will be an interesting challenge for people coming out of graduate schools in Canada with a masters in Marriage and Family Therapy. What kinds of jobs will be available to them? In certain hospitals there are departments of Social Work, Psychology, Psychiatry, and Nursing. But where would a person who has a degree in Marriage and Family Therapy get hired? Presently, the family service agencies hire family therapists who have that as their primary identification, but in hospitals, I am not sure where they would be hired. I think that in universities it probably would be the same issue. Where, for example, would someone who has a doctorate in Marriage and Family Therapy be hired - Psychology, Social Work, Medicine, or Nursing?

**Participant.** What do you see as the contributions that we, ourselves, as Family Therapists, can make to address these sorts of dilemmas?

**Maureen.** I think that at all levels we can make some contributions. At the management level, for example, I've already discussed how we can be influential in designing job descriptions and advertisements for positions. Another area is for management to create a milieu where clinical membership is important. Right now, there are five clinical nurse specialists that work with me on our clinical team. They have graduated from the University of Calgary masters in nursing program and are all pursuing clinical membership or have received it. One of the attractions for them coming to the Holy Cross was that we have approved supervisors or, for example, in your program, the fact that you have so many approved supervisors creates a milieu that is attractive for people.

Another thing that clinicians can do is identify ourselves more as Marriage and Family Therapists to the general public by getting involved in the media and responding to health issues, women's issues, men's issues, etc. I believe that the 1990's are going to be the decade of the family and the environment. People are looking at larger systems and basic values. So I think that family therapists can identify themselves more and have more of a say about how they see family life being impacted and how they see the role of the family. If you think of the concept of "feed forward," that people are looking to the millennium and thinking "its the last decade before the millennium so what do we want to leave posterity?", then there will be more of a focus on basic values and the family. This concept is not an original idea with me. I read somewhere recently that the extravagances of the 1980's and the "me" generation really are not "in" these days. People are talking more now about the environment, posterity, values, and ethics. You can't pick up a journal that you don't read ethics articles or look at conference brochures where you don't see an emphasis on ethics and basic values. When you talk about ethics and values then I believe you naturally start to think about the family.

**Participant.** There is a a kind of synergy going on.

**Maureen.** Yes, yes. I think so.

**Participant.** One thing that I have been thinking about in respect to professional education is the possibility of this university establishing a Family Therapy Department. I wonder if you have any comments to made?

**Maureen.** Oh, I think that would be wonderful. Many years ago, Karl Tomm organized an interdisciplinary committee. I remember going to those meetings back in the early eighties with people from Educational Psychology, Nursing, Medicine, etc. trying to establish a masters in Marriage and Family Therapy. There was great interest from the diverse participants. I think that when it finally went through the university committee "mill" system, the finances and the down-turn in the economy did not promote the concept. It is a big undertaking for disciplines to cooperate to have that kind of program. I believe Calgary is the centre of FT in Canada and a lot of credit

for that I give to Karl Tomm. Karl finds new talent in Family Therapy and brings them here. No where in Canada that I know of and very few places in North America seem to have the exposure to the kinds of family therapists that Karl brings here. Its tremendous.

**Participant.** Would you see any conflict of interest if an university accredited program were to be established in relation to your program?

**Maureen.** No. I don't see any conflict of interest. I see it as quite complementary because as you know for clinical membership in AAMFT what you need is 1000 hours of direct client contact and 200 hours of supervision. A masters program would need to provide 500 hours of direct client contact and at least 100 hours of supervision. A graduate coming out of such a program would potentially look to a program like ours that is a post degree program to help them acquire those hours.

I see a masters program and a post degree program in Calgary quite complementary. I think Karl Tomm provides an international flavor by bringing noted speakers to Calgary and our program provides the post degree training. In addition, there are several other wonderful centres for family therapy practice in Calgary.

**Participant.** How do you see your own role, Maureen, in the field over the next few years?

**Maureen.** Well, I see myself continuing to be involved with the Commission. I've been on the Commission on Accreditation now for four years and it is a good fit for me. It has been a wonderful opportunity to learn about accreditation. I'm very grateful to Ken Hardy who was the Executive Director of the Commission for influencing me in that direction. I've also just been asked to serve on the Strategic Planning Committee for AAMFT. This consists of the president, president elect, and about five other people examining mid range and long range strategic planning for AAMFT. They have just begun the process. I think it will be quite exciting to be part of that and believe it is very significant that they wanted to have someone from Canada on the Committee.

**Participant.** Are you the only Committee member from Canada?

**Maureen.** Yes. It is a small group.



Within Alberta, I see our program at the Holy Cross continuing to develop a solid post degree Certificate Track. We have just taken in our second group of interns so they are very young in the Certificate Track. We've had the Continuing Education Track running for five years.

Personally, I see myself over the next several years being really interested in families and larger systems. We have just started a Family Systems Nursing Program in the Medical/Surgical area of the hospital here. We have developed a Family Nursing component within the Family Therapy Institute. In the past five years, twenty-five staff nurses have been trained on the inpatient mental health unit how to assess and intervene with families. Now we are expanding the Family Systems Nursing concept to the Medical/Surgical area. I just talked to the nursing unit directors from the medical and surgical units about two weeks ago and we will be doing a workshop for Family Nursing Committees that have established themselves on the med-surg units. I think this will be fun! It will be a challenge!

I had a wonderful opportunity to visit the Ackerman Institute in New York in the spring and met with Howard Weiss, Ph.D. and Don Bloch, M.D. Howard directs the Family-School Collaboration Project there where they are looking at developing more collaborative family and school relationships versus adversarial relationships in the New York school system. I thought that some of Howard's ideas could be adapted for the family-hospital system. We plan to introduce a Family Systems approach on the units. It doesn't make sense to teach the nursing staff how to do genograms or assess families when that is not their area of expertise. But to look at family-hospital interaction would be their area of expertise. For example, when someone comes in to have surgery, how would that patient's family be involved? How would the professionals interface with the family?

**Participant.** That's very interesting-also heart warming to see that there will be more consideration of what actually happens that might interfere with helpful outcomes.

**Maureen.** That's right! I would like to give you an example of what can happen in hospitals around discharge planning on some of the long term medical units. The social worker has met with the

family to discuss discharge planning. However, sometimes the prime nurse is stopped by the family member in the hall who says "I really don't think that my mother should go to that nursing home". Then ten minutes later another adult child stops the nurse and says "I think my mother should definitely go to that nursing home". We believe the nurse needs to understand the whole concept of triangulation, the concept of interdisciplinary cooperation and not "get caught in the suction". I think those are the kinds of areas we will be working on. We will be refining their skills in looking at reciprocity and recursiveness.

**Participant.** Do you see the possibility of the implementation of training in your institute of the approved supervisor designation as a near future development?

**Maureen.** I don't see it in the near future, quite honestly, and the reason is that our resources are so limited. I see there are other ways people can get the training. I envision us concentrating our efforts more at training clinicians rather than supervisors. People interested in becoming approved supervisors can attend the AAMFT annual meeting where they have the approved supervisor track. They can also participate in different institutes or workshops at the annual conference. In addition, they can team up with an approved supervisor for directed study. I also believe that Brigham Young University has a distance education program for approved supervisors. So I don't see us as providing that type of training.

**Participant.** What are your views about your gendered experiences of being a family therapist?

**Maureen.** Well, I'll tell you I struggled with that question and thought that I do not have any experience of being a non-gendered family therapist. So it is hard for me to comment.

**Participant.** I'm sorry. I didn't understand that.

**Maureen.** I don't have any experience of being a non-gendered family therapist - my gender and my experience are one.

**Participant.** All right! Fair enough!

**Maureen.** It's like someone asking a twin, "How does it feel to be a twin" and the person answers "Well, I don't know as I've never not been a twin!".

**Participant.** Maybe then the ques-

tion is a poor one. What are your views about the differences between the experiences of being a female versus a male FT?

**Maureen.** I think that in the family therapy profession there are more females that belong to AAMFT than there are males. And yet the administrative structure tends to be more male dominated than female. Personally, I have never found being female difficult in terms of entering into the family therapy field. For example, three of our four faculty in our institute are female and five of the eight adjunct faculty are female. The outpatient team that I direct at Holy Cross happens currently to be all female. This was not by choice or by design but rather just happened as positions came open. We wanted the best person for the job.

Quite honestly there has been some disadvantages to having an all female team. I am delighted that one of our new interns is male because that will help us clinically. We sometimes want to have the two genders behind the mirror to be able to say "the men think this while the women think that." Also, some clients will do better with a male therapist than a female therapist. So, I think there are some limitations to having an all-female team.

In terms of the experiences of female family therapists versus male family therapists, I could go into a lot more issues but these are the sort of issues that you've read about in the literature. In Goldner's work or Frank Pittman's work there is much to be learned.

**Participant.** You'd like to represent gender issues from the perspectives of both genders?

**Maureen.** At times, yes. I think in consultation and supervision groups, it is useful to have both genders because males and females approach some issues differently. It's more stimulating to have differences than to have only similarities. That is not to say that all women think the same or all men think the same. One gender issue that we have dealt with in the last year has been the perception of the larger system about our all female team. Initially, I would hear rumors through the grapevine that people were wondering how an all female team would work out. But now people say, "There is a competent group of women therapists on that team!" So gender is not an issue anymore!



*Participator.* You're inclined to the idea that we can bring forward competence as a major variable rather than the issue of gender?

*Maureen.* Yes. That is the way I would tend to think.

*Participator.* What about the family systems approach with respect to gender issues?

*Maureen.* Well, certainly I do buy into the idea that one of the limitations about the systems approach has been to think of all people in the system as equal. This is something we teach interns to look at in our own work. Some people seem to hold more "equality" than others in families whether this is because of gender or because of money, or because of education, or age.

*Participator.* Do you mean more "equality" or more "power" or "strength"?

*Maureen.* I mean equality in the sense of power and strength. Often times I think our stereotype is that the male is more dominant and the female is more "unequal" but I also see couples where it is the opposite. Also, in some ethnic groups—age and lineage have more power. What I have learned is that a limitation of systems work is that "a part is not a part." Do you know what I mean?

*Participator.* The parts of a Family System are not equivalent.

*Maureen.* That's right.

*Participator.* What do you see as the challenges that we face in the FT field over the next decade? What will be the primary issues that we may have to contend with?

*Maureen.* I think the one talked about before is the definition of profession. I see that as the legislative committee gets more active in trying to define what the standards for Marriage and Family Therapy practice are, then the definition of the profession will be more of an issue. Within AAMFT itself, there will be the issue of the "Professional Affiliate" category of membership. This would be a way of bringing under the umbrella of AAMFT people who now have no home—but have an interest in MFT. I find that quite exciting because I could see that family sociologists might want to join AAMFT as professional affiliates. There would be the clinical professionals within AAMFT but then there

would be other folks who would affiliate with the clinical members.

Another area that will be a challenge is the area of training and job opportunities. As people emerge from the masters programs in marriage and family therapy and from our post degree program, the market place will be influenced.

Some of the other challenges that I envision are more generic to the field. I believe there will be an increasing proliferation of FT models. In the 1960's there were psychodynamic, integrative, and communication theories. In the 1970's and 1980's there was structural, strategic, Milan-Systemic. Now there is post-milan, Michael White, David Epstein, strategic, solution focus, etc. I think the exciting thing will be to see if we as clinicians can integrate some of these models. A "down side" could be that clinicians could become very scattered and fragmented. If clinicians use a dab of structural theory and a dab of Milan, questioning, etc., I do not believe that in the end families will be well-served because the approach will be too scattered. This will be a big challenge in the field, in general, not only in Alberta.

Another area is research. I think there will be much more emphasis on family therapy efficacy. The government in Alberta is looking at cost containment and case mix. In the States there has been the development of DRG's (Disease Related Groups) where third party funding is given to hospitals based on a patient's diagnostic category. In Alberta and in Canada we have not gone to DRG's. However, there is much more of a trend in hospitals to see what kind of patients we are treating and that will translate into what kinds of families we are treating. There will be an emphasis on the efficacy of the therapy and the cost of that therapy. So I believe there will be more outcome research because of these budgetary constraints. Actually, I think this is a wonderful challenge. We should have more outcome studies.

Clinically, I think the challenge over the next decade will be to look at larger systems. The cutting edge of family therapy as we talked before is, I believe, larger systems. We will continue to see family therapy involved with some of the larger problems in society such as violence, drug abuse, and other social issues.

*Participator.* That is good to hear! What I wanted to end up with is how can those of us in the field foster the FT profession? What can we do?

*Maureen.* I think we need to do more of what we've already begun and what we've already talked about in this interview. For example, doing this kind of a newsletter is a way promoting FT as more than just an interest group. We have a distinct body of knowledge that we're familiar with and that we can share.

*Participator.* I don't know if you have any summative remarks.

*Maureen.* Summative remarks? Well, I think your questions have been very thorough and very provocative. They certainly made me think. I was curious to see what you had in mind and I think that the idea of a newsletter is an excellent one.

*Participator.* Well, I would like to thank you on behalf of the family therapists in this area for the work you are doing to increase the credibility of our profession and to facilitate FT being done for more and more people.

*(Interview questions were provided to Dr. Leahey by Dr. Carol Liske)*



The 25th annual "Part of the Problem" convention



# Violence, Sex, And Therapeutic Healing

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The young woman looked younger than her 18 years as she sat looking at me, eyes wide, hands trembling in lap, trying to maintain a placid expression. Her face of anxiety about being in this place at this time betrayed her youthful attempts at engaging humour. Mary, diagnosed as having schizophrenia, her primary nurse, and I were alone in a quiet room to talk about what Mary had, for six years, believed to be unspeakable: the fact that she had been sexually assaulted at the age of 12.

I was called to the Unit to see this young patient when on this, the most recent of her many admissions to hospital, she decompensated just prior to discharge. According to staff reports, Mary had been doing well during her hospital stay; recovering from the schizophreniform symptomatology with the aid of medication and milieu therapy. However, just as she was about to be placed outside the hospital Mary began to show symptoms of extreme anxiety, agitation, avoidance of interaction, and breakthrough anger. During one outburst, she apparently stated in anger that no one had ever asked her about her sexual history. She believed that if the staff had asked her they would have known that she had been raped and they would have been more help to her. The staff quickly inquired into this and as Mary began to settle with their support, interest, and changed medication regime--a tragic story unfolded.

At the age of 12, Mary and a similarly-aged girlfriend, were walking across a city park on their way home when a man stopped them to ask them for directions. As they tried to explain to him the directions he was requesting, he pulled both girls off into the shrubbery and under threat of death, sexually assaulted each in turn. The girls, both prepubertal, were obviously terrorized and humiliated. Mary spoke of going home hoping to have some understanding and support from her parents. On blurting out the story, her parents responded to their shock and dismay by saying that she had no right to be in the park at that time of day, and that she knew better than to talk to strangers. Apparently Mary's girl-

friend experienced a similar reaction from her parents. The event was hushed up and Mary was not permitted to go to the authorities. The girls were mostly left to their own devices as both families seemed best able to deal with the event through silence and secrecy. This, of course, invited Mary and her girlfriend into a special and unique friendship which blossomed over the next year or so. When Mary was 13, during a sleep over that she and her best friend arranged, the friend began to explore Mary's body sexually when she believed Mary to be asleep. This brought forth feelings for Mary that were similar to those she experienced when the man used her body without her consent. She became very frightened and broke off the relationship with her friend. A year-and-a-half of personal isolation followed. At the age of 14 1/2, Mary fell in love with a teacher at school and began to write her love letters. The teacher, rather than dissuading Mary from experiencing these kinds of feelings, acknowledged Mary's feelings for her and gently helped her understand that these feelings could not be returned because of the teacher/student relationship. Mary remembers being very hurt by this, however, she came to accept it and subsequently, at about the age of 15, fell in love with one of her best girlfriends. After Mary realized that her love also had a sexual component, she experienced her first psychotic break and was diagnosed as having schizophrenia. Since that time she has been in and out of hospital on five occasions with average stays of three months. Over this time she was also removed from her family and placed in a series of foster homes. After her current hospitalization, she was expected to move into an independent living situation.

During my first meeting with Mary, I chose rather than to repeat all the details of her history, to confirm that I had read the chart and understood her distress at having to talk with me. I then spent time personally engaging her. I found her, although sedated, to be highly forthright, easily able to follow questions and conversation, and more often than

not direct in her response. She would, at times, show affective upset particularly when approaching the subject of the early sexual assault. Eventually, I experienced our conversation to be sufficiently genuine and engaged to ask her the following questions.

"I am curious," I said, "after the events in the park where that man took advantage of your body for his own purposes, how do you think others saw what happened when you told them of it? Did they see it more as a sexual event, or more as an event of violence?"

"Sex," said Mary without hesitation.

I next asked, "How about the professionals that you have seen, such as here at the hospital? Do you think that now that they know these things happened to you, that they think of what went on in the park more as an event of unwanted sex, or more as an event of violence?"

Mary looked around the room. Eventually her eyes landed on her primary nurse, who she had already admitted was a special strength for her recently, and then looked back at me with doleful eyes and said, "Sex. Didn't they ask you, the *Sexpert* to come and talk to me?"

Then I asked her, "Mary, how about yourself? When you look at what happened those six years ago, do you now see it as more a sexual thing that was unwanted and wrong, or more as an experience of violence?"

She looked at me with confusion on her face, obvious distress in her reflection and said "I have always thought of it as sex, but it never seemed to be something that I wanted."

Mary's story is familiar to many of us. Hers may be dramatic due to her youth, the severe symptomatology following the event, and what appeared to be, primarily, a lesbian sexual orientation. However, what struck me most about her experience was its chronicity. I wondered how she was able to continue carrying such a great burden of upset, despite what appeared to be many attempts on her part to heal from the assault.

The intent of this presentation is to provide clinicians with a potentially useful way of helping clients make experi-



entially useful distinctions between sex and violence that can therefore enable them to begin their healing processes. What I intend to offer here is not a panacea for all experiences of sexual assault or abuse, nor is it something that will fit for all persons. However, I have found the distinctions that are offered through this way of working to be helpful to clients and significant others alike.

In talking with Mary it appeared to me that despite what must have been an exceptionally violent experience at the age of 12, she had for many years internalized the experience as somehow being sexual in nature. Further, she believed that others in life—friends, family, and professionals—also saw what occurred as some form of abhorrent sexual activity. It was my hypothesis that this internalized conversation of believing what occurred in that park was sexual rather than violent had added significant disability to Mary's experience. Perhaps sufficient burden was added to direct her to the clinical state that she showed at the moment. This hypothesis was generated not only from Mary's story of her own experience, but from that of other clients I have seen. For instance, husbands of women who have been sexually assaulted often feel that somehow their wives have been sexually interfered with, or the women themselves may feel that their sexual lives are ruined.

In part, such attitudes and beliefs make sense when the social context of our understanding of sexuality and violence is taken into consideration. For instance, if one looks at Webster's Dictionary (1983) for a definition of sex it is as follows:

*The sum of the structural, functional, and behavioural characteristics of living beings that subserve reproduction by two interacting parents and that differentiates males from females.*

While this may technically be a correct definition of sex as it relates to assigned gender, it is not by any means what most people think of when they speak of sex. If one were to then look up the definition of *sexual relations* in Webster's, there is a single word: *coitus*. Using this definition, the fact that Mary was penetrated at the age of 12 by a man's penis, puts the act into the category of sexual relations. However, it has always appeared to me that such a perfunc-

tory definition of sexual relations (i.e., one based on penis penetrating a person), has significant short-comings. My impression has been reinforced during the years of my clinical practice through talking with patients about their disturbed sexual experiences and what it is they have actually been hoping to experience instead. One way I have found helpful to orient people to their intended experience is to ask them to reflect on other positive experiences. On many occasions I have asked people to close their eyes and bring forth in their minds (without acting on the recollection or saying anything aloud about it at that moment) one of their better sexual experiences of life. Without fail in Western culture people's best sexual experiences include the following (Sanders 1989, 1988):

1) Each person involved in the sexual activity experienced themselves being there *volitionally*, and that each experienced self and other as having access to emotional and physical *sexual arousal*.

2) This volitional arousal occurred in an interpersonal context of *intimacy*: simply meaning *mutual emotional/physical vulnerability* in a larger context of *trust* that the vulnerability would not be taken advantage of.

When I then ask people to open their eyes and compare the playback of this *experiential definition* of sexuality to their inner reflections, I invariably receive agreement between the two. Occasionally, however, someone may say, "Well, I remembered an anonymous sexual experience where I didn't know the other person involved. The sex itself was quick and intense--in fact, it was one of the best!" Yet even for that brief instance, both participants knew each other to be there for sexual reasons. They knew the events were mutually arousing and both experienced the activities as volitional. It also occurred in a context of brief, but very intense intimacy: mutual vulnerability with trust that the vulnerability would not be taken advantage of.

The difference between this experiential definition of sexual relations and the simple behavioural definition of coitus as sexual relations is profound. Using a behavioural definition--coitus--one can either inadvertently or purposely ignore the experience of either or both of the participants in the activity. By using an experiential definition, one is not limited

to a single form of behaviour in order to bring forth that experience.

Sometimes I have wondered how it came about that sex is defined as intercourse or coitus alone. I think perhaps two things have contributed to this definition. The first is the nature of reproduction and its dependence on coitus for effective species procreation. This may invite people to see the sexually reproductive act as *the act* of sexual relations. However, it has been known for three decades that women and men have differential physical opportunities from intercourse simply by the nature of their genital structures. Whereas men have the most intense feeling in their penis plus use it for intercourse, women have the most intense sexual feeling from their clitoral area while using their vaginas for intercourse. Although many women find intercourse pleasurable and even sexually exciting to the point of orgasm, it is known that men need to learn to slow down to match the timing of sexual excitement with their female partners. It is also known that many women are not able to regularly count on orgasm during intercourse simply because intercourse itself is not sufficiently physically effective, although its intimacy value is reported as intense.

The second factor that I think may have been important in defining sex behaviourally and not experientially, has to do with the tradition in our culture of patriarchy. Here, I am interested in patriarchy as being society-organized according to the principles of male experience having relatively more importance than female's experience. One can see that within such a social understanding, if a man is gaining personal pleasure from penetrating a woman, no matter what that woman's experience may be, the activity is seen as sexual relations.

It is my hypothesis, therefore, that these two factors (intercourse as necessary for sexual reproduction, and the prioritization of males' arousal experience over that of females) have defined sexual relations as the fact of intercourse. Such a definition only helps to blind us to what most appear to be seeking--the personally felt experience of *mutual sexuality*.

However, when we look at Mary's story, I think for almost all of us it would be clear that what she experienced during the event in the park was violence.



Humberto Maturana's (Maturana 1986) definition of violence is:

*The holding of an opinion by one person or group to be true such that another person's or group's opinion is untrue and must change.*

Using this definition, it becomes unavoidably clear that what occurred in the park that night was, indeed, primarily violent. However, Maturana's definition is a broad one and would include many actions that we in society might not usually consider as violence, such as, sending children to school against their wishes, or incarcerating criminals.

The observation that some violence appears to be acceptable and some unacceptable can be understood using the notions of social responsibility and acceptability. The social acceptability of violence changes from one time to another and from one culture to another. For instance, it is currently illegal for parents in Sweden to physically spank their children. It has become increasingly unacceptable in Canada, although it is not illegal. This is a far cry from just two generations ago when the phrase *spare the cane and spoil the child* expressed a common and accepted idea. Similarly, at times of war the actions of "raping and pillaging" seem to be accepted as something that conquering armies are apt to do. Unfortunately, our social tradition of patriarchy and the subsequent emphasis on patriarchal values (i.e., property and ownership), tend to promote violence as something that is simply a damaging physical interaction between a non-owner and the owner's *property* no matter what the individual's experience of that interaction. If, as with some sexual abuse or sexual assault, no damage was done to the *property* (the *victim*), the tradition of patriarchal values does not see the transaction as violent. For the last two decades feminist writers have been inviting us to understand that violence has as its primary and most fundamental meaning, the experience of those who are subjected to it.

There are three basic distinctions that I have found to be useful in helping patients begin the process of therapeutic healing from events such as sexual assault and sexual abuse:

1. Sex - defined experientially and based on mutuality;
2. Violence - defined as the imposing of one's will over another; and

**3. Personal responsibility** - defined as the ownership of one's actions within a context of social acceptability.

However, the challenge has been to introduce these notions to clients in a way that they can readily understand them. Additionally, if they are able to carry the ideas with them over time and apply them to their own experience, a meaningful internal conversation can develop that permits the option of a higher quality experience of life.

My goal in talking with Mary was to introduce these distinctions in a manner that may help her discriminate the elements of her experience more clearly and benevolently. Such clarity would then offer her opportunities to develop greater health and personal validity. It is my intent in therapy to purposefully offer these increased socially responsible opportunities to those clients and persons experiencing constraint or restraint. In my work with Mary, I wanted to *offer* these opportunities to her rather than require she take my help.

I decided to introduce what I have come to call "the baseball metaphor" after Mary told me of her belief that important others in her life thought of what occurred in the park as sex and that now, despite her own experience of it being unwanted and imposed, she also thought of it as being somehow sexual. It has been my experience that this metaphor can be useful to both men and women who have experienced sexual assault and/or unwanted, inappropriate sexual activity such as sexual abuse. However, in order for it to be helpful, I believe it must be introduced in a caring and considerate manner and while the client and professional are well engaged.

I looked at Mary and I asked, "Do you play baseball?"

She looked back obviously perplexed and perhaps even thinking, 'He's the one showing bizarre thinking and I'm the one diagnosed as schizophrenic.' "Yes," she replied.

"Well, please bear with me for a short while. Let's pretend for a moment that you are in a baseball game. You're the catcher and it's the last inning of the game with the last batter up. The batter has one more strike before being out and if this batter goes out, your team wins. Let's pretend that this is a fun game between two teams on a Sunday afternoon. Both teams have been enjoying them-

selves and are looking forward to the end of the game so they can move on to celebrate. As the pitcher throws the ball, the batter swings with great effort, misses the ball, and you, as catcher, catch it. You now know that the game is over, your team has won, and the follow-up parties await. However, before you can fully recover your balance from the catch, the batter turns and with full and mighty strength, swings the bat hard across your head. If this were to occur, would we call this baseball?"

Mary looked at me, eyes wide, obviously thinking and said "No."

I said, "I'm curious, why should it be that if a man uses his genitals *against* a woman, we would call it sex?"

It was Mary's response to this question that has prompted my talking about this in professional circles. She looked at me, silence in the room. Initially I could not read her expression but slowly tears began to roll down her cheeks, softening her stony look.

On many occasions since this session, I have asked professionals what they believe Mary was emotionally experiencing at the moment of her tears. Many women say, perhaps relief. Many men state, perhaps sadness at the time lost. But, in fact, when I asked Mary to tell me of her tears, she looked at me, and angrily said, "You mean I had to wait all these years to learn this?"

It was this anguished cry of a youth who had spent six years of personal turmoil and torment following an act (that was clearly experientially violent) with confusion as to its sexual implications. I have found the fact that the implications had taken on a larger influence for her own personal development to be especially poignant.

Once I validated her anger and her right to be upset that this had taken so long, I then began to inquire of her ability to work with this concept over time, particularly with her primary nurse. I asked, "If the professionals also thought this way, would you find it helpful in coming to experience yourself as more healed around the events that occurred those six years ago or would it make little difference?" "A big difference!" was her response.

The issues of violence, sex and social appropriateness were not all that Mary was struggling with. Her many years of hospitalization, family disrupt-

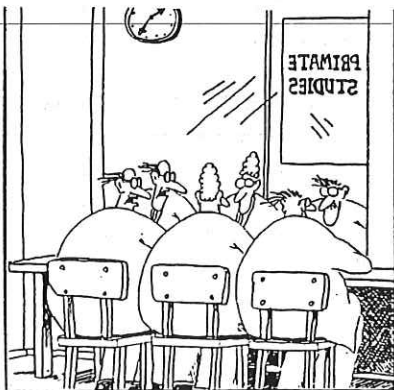


tion, and difficulty accepting her lesbian orientation and its meaning, when taken together were significant and powerful invitations to disruptive behaviour and experience. Nevertheless, this simple *baseball metaphor* permitted Mary to both cognitively and experientially recognize and begin to internalize more useful distinctions of the sexual assault than that which society had offered her. The intervention also became available for professionals - those who would read the consult, who would talk with the primary nurse in attendance, and who would talk with Mary herself.

Although I saw Mary on one or two more occasions and her clinical status improved dramatically and remarkably over a short time, I am not sure exactly what happened to her later. I did see her in a store a year or so after our first meeting. I do not think she saw me, however, from across the store, I saw her interacting like any other shopper - buying a Walkman from a salesperson. I do know that for other women and men and their spouses the baseball metaphor has served as a concrete and identifiable foundation from which to start meaningful healing after the traumas of sexual assault and sexual abuse.

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"For crying out loud, gentlemen! That's us! Someone's installed the one-way mirror in backward!"

# Sexplay

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## Sensual delights anyone?

It is late. Each has worked hard at her or his day's preoccupation. It could be the office, the kids, the neighbours, the hospital, the plant - it could be simply trying to scratch enough stamina together to go for another day. The News is over, the TV off, the bed looms. Exhausted, the couple falls into the softness of the mattress. One looks at the other, reaches out a tentative hand, only to either pull it back at the first sign of the other's displeasure or quickly move on to a sexual interlude that seems quicker than the 30 second break between the National and the Journal. As sleep takes over from furtive lust, each wonders "Where did the fun in sex go?"

How familiar is this scenario to today's therapists? For most of us, we hear it or some other variation all too frequently - either in our clients' lives or our own!

Imagine if we looked at sex like we do eating. For instance, try imagining prescribing or partaking in a *sensual dinner* with the person of your choice. Sure, you could "eat" at fast food outlets and get over-processed, - under-spiced, - mostly tasteless food. If you did, however, you would acknowledge the limitations and look forward to either a home-cooked meal or a special treat the next time you went to your favorite *real* restaurant. Here, on the other hand, is another way you could arrange a sensual delight.

Arrange a time when the two of you (for propriety's sake I will suggest only two) can spend a few hours together in private, protected from outside interruptions like the phone and door. Agree that this will be time for a special meal.

Now, sit down and arrange a *menu* - you know the various courses and tasteful bits that you would like to have at your sensual dinner. Pay attention to the different textures, smells, and appearances as well as the taste itself. Be luxurious with yourselves - its your meal!

When the day of the meal comes, get together an hour or so before you wish to prepare it and cooperatively go shopping for those food stuffs needed to complete your menu. Then, work cooperatively in the kitchen preparing the meal. Sure, one of you may be a better cook than the other, which means one of you will be the lead hand the other the helper.

Once prepared, get ready to eat the meal. But wait! There's more! - a set of unique instructions to aid your meal being different than many of the more recent attempts at sensual delight:

1. prepare a place to eat that emphasizes senses other than vision and hearing - that is taste, touch and smell. This can be simply done through eating in softer light, playing pleasing music that is not distracting and so on.
2. choose a place to eat that is unusual-- avoid the kitchen or dining room.
3. eat anywhere but on a table - for instance try the bath tub, the bed, the floor and so on.
4. do not speak during the meal.
5. use no utensils to eat with.
6. do not feed yourself.
7. enjoy yourself.

As you can see, such a *meal* appears to resemble a child's experience of eating. What is different, however, is the parallel between eating this way and good sex. Each refocuses his/her experience on the richness of sensuality; struggles with non-verbal communication; becomes aware of issues of pace, duration, etc.; and implicitly held expectations about both self and other as they *eat*. Most of all, though, is the commitment to set aside the *opportunity* for a mutually enjoyable time that is fun, sensual, and filling!

### Bon appetit

(p.s. - One couple I worked with swore by well-seasoned linguine, followed by chocolate fondue!) 🍏



# Story-Connecting: What Therapy is All About

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**The untiretles of livesliving being the one substance of a streamsbecoming.** *James Joyce*

I propose that it is inherently therapeutic for a person to imagine her life as a story. I will go further and suggest that the simple act of contextualizing a troubling situation into the setting of a life story can be equally therapeutic. These proposals are derived from a fundamental assumption I am making, namely, that the way human beings construct reality is by narrating it into existence. We make sense of events and explain them to each other as stories but we less frequently place these narrations into the larger setting of "the whole story" of lives being lived *through* such dramas. Still less frequently do we appreciate the connection between one person's story and another's as, by the actions of each, each enters the other's story, becoming an important character in that person's story, as they remain the main character in their own. Even less frequently do we connect our own life stories to the larger stories of our communities, our gender, the human race, the story of the universe, and the extreme--life itself! The overarching claim of my position, then, is that the more often isolated stories are connected to other--"larger"--stories, to provide "continarration" (Joyce, 1939), the more meaningful and rich we make our lives. Therapy is, from beginning to end, *story-connecting*.

As soon as we begin the process of placing an event in our lives into the setting of a life story, anyone involved is placed, first of all, into the capacity of an observer of her actions. Moreover, she becomes an observer of this particular event as only one of many over time, all of which she has survived. Secondly, it makes her immediately into the author of her own life story. In so doing it makes her into an actor, an agent, of her life so that she becomes more able to direct her life according to her own choices. Furthermore, once a person has been encouraged into the twin positions of observer and author of her own life story, within the setting of her family story, she is enabled to view her life and take charge of it

both retrospectively and prospectively.

## Case Example

Marlene found herself embedded in the ugly aftermath of a marriage that ended, for her, amidst an intense feeling of betrayal. Her ex-husband and his new partner had been harassing her on what she felt were issues only aimed at hurting her in order that her ex-husband could justify his previous actions. After hearing the family's presenting concerns, I asked her to tell me, in effect, the story of her life. In the next sessions, Marlene told me that the act of telling "the whole story" had placed the recent events about which she had been feeling so powerless into connection with so many other events in her life that she had gained a sense of perspective and understanding of all she had been through. From the empowerment she experienced in this perspective she found new effective ways for dealing with her ex-husband. She was now able to act much more from a feeling of confidence as one who had a sense of "being-in-charge" of herself.

The empowering implications of what it means to be able to look backward and forward on her own life arises out of the experience of finding her own voice and using her own words to describe her own experience. This occurs when a person finds someone to whom to tell her story who gives it validation by listening. This "telling" in itself replaces what is apt to have been the invalidating practice of understanding herself according to other people's descriptions of her experience. This can occur, for instance, when a parent says something like: "What have you got to be unhappy about? You should be happy just to be alive!"

When a person finds her own voice and is able to use her own words "to encounter...the reality of experience" (Joyce, 1947, p.526), such that the latter becomes the thread that her memory follows, her history itself changes. Events in which she had remembered herself being described as bad can now be remembered in her own experience as times when she was doing her anxious best to

please someone. Her heartfelt effort had been the very opposite of what had been ascribed to her. Affirming herself by virtue of a "new" past, she can now direct herself toward a future story that is her choice. Changing the past in this way is a vital ingredient in the story-connecting therapeutic process for, as a person begins to use and trust her own voice, she not only remembers various formative events according to her experience of them, but she commences the vital business of changing the plot of her story. A story by itself, after all, need only be comprised of a description of a sequence of events connected according to some criterion of selection: "Danny came home late again so this time we grounded him" is a line in a story. *Plot* pertains to why the various characters are acting as they are. It is what gives a story its character and makes it interesting. The following extension gives the story line a plot:

Danny showed his defiance by coming home late once again. He thinks we're treating him like a child. We felt we had no choice but to ground him for the worry his 'independence' causes us.

People come to see therapists, in effect, because the plots of their stories are not going as they want them to go. Because the various characters in their life stories are thought to be acting for certain reasons, they find themselves re-"acting" for reasons that are felt to be justified but which result, over and over again, in unsatisfying outcomes. Such combinations of assumptions may have accumulated to the point where the individuals involved find themselves unable to act according to their own choices.

## Entering each other's stories

It is, however, only possible to freely choose to the extent to which each person faces the realization that while she can be the main character in her own story, so can everyone else in their own respective stories. Each of these others who so frequently seem to stand in the way of her getting what she wants, is a supporting character in her story and that



is the best she can hope to be in theirs. If she would obtain what she wants for herself, so that her story can go forward, it is necessary for her to consider where her actions and attitudes may fit in the stories of those whom she wishes would play her story's supporting roles. A lived story, in other words, differs markedly from a merely written story in that her freedom to author occurs within a context in which all the other characters are just as autonomous as she is. They can only be persuaded to play something like the role she wants them to play to the extent to which she is willing to play a similarly helpful role in their stories. All the world might be a stage and the men and women in it merely players, but we are players, each of whom is following her own script. Accordingly, each must either find, by resort to some tacit code, others who are playing a role that happens to fit one's own in a complementary way so that neither party has to improvise much and the scripts of each move to their appointed ends, or else one must be prepared constantly to improvise upon one's script to the degree necessary to persuade the other that participating in the "play" is likely to be advantageous.

There is even a better way, a bit daunting though it be, and that is to actively seek to play a supporting role in the story of the other. This act may be said to be the aim of therapy itself. It is the way of improvisation and necessitates each extending oneself to *hear* the other's story and to understand as well as possible one's place within it. Through listening to the clarifying of the motives and intentions of the other, the revision of the old story plot is enabled, and thus, she is nourished toward seeing herself as her own heroine.

### Case Example

Peter was a person who was trying to escape a tragic tale of blatant rejection and abuse for which he blamed himself. When he began to root his new story in his own experience of himself as one who was earnestly trying to learn "what the heart is and what it feels" (Joyce, 1947, p.526), he initially experienced bitter disappointment from one whom he believed truly loved him. Once he considered that this person was not only destined to play a supporting role in his new story but was living out a story of her own in which he was a character from

whom she wanted a certain kind of support, the story of her pursuit of love could best be advanced by Peter improvising on this experience to learn in an unexpected way what her heart as well as his own felt about love.

### Connecting to larger stories

Every meeting with another person is an event in two stories. Each must, therefore, consider her actions as an entrance into another person's story with the other person's actions considered in the context of such a connection. Our stories as individuals and as families can also be seen in terms of their connection with even larger stories. Each of us, in the lives we lead, enter into the stories of our various communities of identity: those of the place, nation, society in which we live; and those related to gender and any hitherto marginalized group to which we belong. Also, we may consider ourselves inescapably to be part of the human story, the Earth story, the universe story, and the story of *be-ing* itself.

When we consider these vast dimensions to which our individual and family stories are connected, it introduces into the therapeutic story a potentially very impactful new element. While, at first blush, it might seem quite beyond the task of therapy, perhaps even a bit grandiose, to be addressing issues touching on "the meaning of life," it may be that a failure to appreciate a larger significance to one's actions plays a dominant role in the concerns that individuals and families bring to therapy. Thus, a very helpful question with which to wrestle during the more reflective phase of therapy might be whether a person wants her new story to be part of the all-too prevalent societal story of domination, exploitation, and colonisation (Kearney, Byrne & McCarthy, 1989, pp.17-31), or whether she wants it to be connected with the human/Earth story of liberation and stewardship. By reflecting in such a manner, the person(s) involved become able to place the implications of their actions onto a wider stage, as part of a story much larger than themselves of which they are, nevertheless, a link, without which even Great Stories will be, to some extent--frustrated.

This stage of story-connecting can be of particular benefit to people in relation to their gender membership. Women

are learning how to connect their own personal new story to the new story that many women today are creating, in re-writing *herstory*, by drawing upon the archeological and historical revisions of such figures as Marija Gimbutas (1989) and Riane Eisler (1987), and by joining together to bring about a different kind of future--beyond patriarchy. Men, following upon the "ground-breaking" work of the poet, Robert Bly (1985, 1990), the post-Jungian, James Hillman (1983, 1990), and others in the mythopoetic movement (1990) are also being shown the way to give voice to a new story about a gentler kind of maleness that had been marginalized while men worked at defining themselves in the age of patriarchy as, in effect, "not-women."

Indeed, we live in a time, often referred to as postmodern in which the credibility of the prevailing story known as *history*, along with the very notion of a unifying, single reference point as supplied either by God or objectivity, have been brought into question. In the absence of such a centre around which to build and buttress an agreed-upon prevailing story, all those who had been marginalized by their exclusion from participation in that story--women, people of color, homosexuals and the variously colonised--have been demarginalising themselves as they have been finding their common voice and telling a series of new stories. The very absence of what the theologian, H. R. Niebuhr, called a centre of value (1966) that a whole society can more or less agree upon, may lie at the heart of many more of the anxieties--that individuals and families bring to therapists--than we realize. Many of the conflicts between even family members, for instance, become as entrenched as they do because the parties to the conflict, "forget" that they share any kind of common story as a family, now seeming to exist in opposing realities. In other words, they are participating in altogether different larger stories.

It is not only confusing but terrifying for growing numbers of people to find themselves in a world characterized by "the unbearable lightness of being," as the novelist, Milan Kundera (1984) calls the postmodern experience. The phase of story-connecting that provides the option for people to *choose* to participate in whichever larger stories they find themselves, may be the most important



for people to create meaning in their lives. It is otherwise difficult, for this is a world in which, as Salman Rushdie proclaims:

No story is the true story or God's anointed story, all narratives are susceptible to being re-written. There's nothing permanent, nothing essential, about the culture we happen to have. Everything's in motion, [up-for-grabs]. (In Edmondson, 1989, p. 68)

### The method of story connecting

How does therapy as "nothing but story-connecting" proceed? As all therapy has proceeded ever since Freud discovered that, in the elementary act of listening to someone tell her story: healing takes place; new connections are made; forgotten episodes re-remembered; and an all-too-invalidated human being finds her own voice. The postmodern temper encourages us to proceed on no other basis than the telling and connecting of stories. It is sufficient for the therapist to remember that story-connecting is not a new theory, is not a theory at all, that, in fact, no theory need underlie a postmodern therapy. Such a therapy could be said to rest on an axiom that "human beings cannot not story their lives" anymore than we can not communicate. The heal-

ing that takes place in therapy is, in other words, entirely in the story-telling and the story-connecting. What I am proposing is simply that we have not yet faced up to how far we can take the practice of story-connecting. The new therapeutic challenge is to not only connect otherwise fragmented and disconnected "episodes" in an individual's story, but to also connect these episodes to the ways one person's story enters the complementary stories of others, and to consider how these interrelationships are "woven" into the larger stories and the Great Stories. If the client(s) enjoys to actively share in the development of the story metaphor, so much the better. If not, story-connecting goes on anyway, for that is what therapy--and life--is all about.

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### continued from page 2

*through the air with her as four o'clock in the afternoon came to an end, and they were lost forever with her in the upper atmosphere where not even the highest-flying birds of memory could reach her. (pp. 222-23)*

This wonderful book suggests to us that if we would live well in a world bereft of a central frame of reference that we plunge into what life itself offers to embrace--and enjoy it! Such a life will not assure us of anything but the lived experiences themselves. In living with impressive imagination, extravagance, and exaggeration, our own lives-- not those of gods or heroes, will become the myths we live by in the places we live them. Nor do these characters simply live by impulse or self-gratification. A certain ceremony, propriety, and courtesy is demanded of a life that would be lived well. There will be terror as well as beauty; sadness as well as happiness; nor will cruelty, unfairness or pain be banished but as much will be possible as we dare imagine. Indeed, imagination places the

only limits on the possible or the permissible. Here, then, is the epitome of post-modern storytelling: that we can do whatever we choose with our stories and it is our experience of living alone that makes the story credible.

*One Hundred Years of Solitude* is the chronicle, finally, of a family like no other in its own place and its own time. As such it is as all families may become. Yet, even in this family, amidst such abundant living, there is no escape from solitude, we each live our own lives, there is no second chance--so all the more reason to live well and but laugh at our follies. Life in the postmodern world, where there are no guarantees, is not an occasion for anguish or handwringing but for welcoming the possibilities that the very absence of any kind of transcendent limit grants the imagination to invent. Solitude is indeed our fate and it cannot be escaped--but in families and places of caring and in the uniqueness of each one of us--lies memory and community. These are our great consolations! ♣

## The 8th Annual Calgary Participants' Conference

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# From Narcissim to Narcissus: The Journey from Bondage

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Recently, after having almost exhausted the integrity of my conscious working knowledge in relation to three long-term treatments, one common occurrence in all these cases seemed provocative to attention. In each of these families at least one member seemed to act as if they limited their outlook or concern to the fulfillment of their own needs and activities. Using conventional, and perhaps psychiatric language, one description of these individuals could be that they seem *narcissistic*. Knowing that this choice of terms *labels* individuals, and may even appear regressive to current FT thinking, my purpose in bringing this notion to mind is to suggest that conscious knowledge about the *effects* of some very specific "styles" of behavioural orientation may—if utilized in wisdom—augment the effectiveness of our therapeutic work. This consideration could, at least, open discussion about some "types" of FT work so that potential difficulties in treating particular sorts of families—are minimized.

Although one perspective about *narcissistic* behaviour might be that there are current systemic elements that invite this behaviour, a temporal frame might help explain its tenacity. Therefore, it seems that an individual's historical context reinforces *bondage* to interactional invitations and that *memory* may play the major role rather than contemporary events. Thus, it is proposed here that the *family of origin* and/or childhood experience of one individual may influence that individual's behaviour sufficiently for it to endure into other relationship contexts and that this endurance may become forceful in current family relationship patterns. This view has been meaningful in better understanding the families under current consideration, as has an extensive examination of the story about *Narcissus*. From this examination, I have come to the conclusion that individuals exhibiting the traits of narcissism are not only NOT *self-centered*, but that they have little, if any, *self-knowledge* whatsoever. Thus, they "look"—in *bondage*—to their external environment to re-

flect their image and to define their *reality*.

The story of Narcissus has been represented by Edith Hamilton (1942, pp. 87-88), a Greek mythology scholar, and is summarized, by the writer, as follows:

Narcissus, a lad of beauty so great that all lovely nymphs longed for his attentions, seemed indifferent to their desires. Over time, Narcissus continued in his oblivious and seemingly cruel manner. Eventually, one whom he had wounded, *Nemesis*, uttered a prayer that was answered by the gods. Thus, *Nemesis*, which means righteous anger, prayed "May he who loves not others love himself!" The prayer was answered when Narcissus bent over a clear pool for a drink and saw there his own reflection. On the moment—he fell in love with it! "Now I know...for I burn with love for my own self—and yet how can I reach that loveliness I see mirrored in the water? But I cannot leave it, only death can set me free." And it happened that he pined away, leaning perpetually over the pool, fixed in one long gaze. From the place where his body had lain emerged a new and lovely flower. The gentle nymphs called the flower—*Narcissus*.

Interestingly, the only devotee of Narcissus who did not abandon him was the most beautiful nymph named *Echo*. However, *Echo* was doomed because jealous Hera had punished her by decreeing that *Echo* would only be able to repeat the last words spoken by others. *Echo* suffered great shame in revealing her love to Narcissus, particularly in the embarrassment of repeating the last part of his spoken words, and suffering his subsequent rebuke for her apparent foolishness. She remained loyal to him until the end, finally repeating his fond farewell to himself. She is said to live in lonely places still but that she has so wasted away only her voice is now left to her.

In conventional usage this "story" about Narcissus has come to represent a story of self-centeredness, egoism, and egocentrism. However, once the myth is examined more carefully, Narcissus can

be seen to have been completely vulnerable to his external environment. In fact, there is little in this tale to suggest that Narcissus had any clear attunement to himself other than through reflections of his most outwardly manifest form. He even showed no evidence of any conscious knowledge about the interface, he himself conducted, in relation to these sources. What could have happened to Narcissus that may have compelled him to access more knowledge about his circumstances and other possibilities for his life? The most likely contingency would have involved some sharp "surprise" in the form of *new information*. One can imagine this information coming from either some maiden showing an unexpected more negative interactional approach to Narcissus, or an incidental natural event such as a strong wind may have stirred the mud on the lake so that Narcissus's reflection was darker and distorted, an image that to him may have been distasteful. Narcissus, in being defined by external elements was always at the mercy of denigration, but he appears to have been unlucky enough *never* to have met with such a fate. Therefore, he was not afforded the opportunity to challenge the viability of superficial identity. Another story of Narcissus could have been told according to the converse situation, whereby he may have only been identified to a vision of ugliness. And had the "Ugly Duckling" believed *that reality*, his fate would have been similar to that when he had only identified with the vision of his own beauty—although it may have been even more unpleasant—it would have been a situation of *bondage* nevertheless.

For some time, the field of family therapy has oriented profoundly toward interactional "invitations" in the assessment and intervention into family patterns, however, it seems difficult not to realize that persons vary in their capacities to absorb or refuse these invitations. Thus, the invitation itself is only part of the interactional story. Would it be difficult to imagine Narcissus's childhood as one where he experienced a high rate of



unilateral perspective? From this condition, his informational encounters most likely would have been perceived to fit his dominant story.

In working with a family who has one or more member(s) showing a limited "range" of ideas about themselves and seeming absorption in their reflection from external sources, an *explicit* inquiry into the family members' perceptions regarding the sources of *self*-ideas can be helpful in initiating a mindfulness about the notion of *self*-definition. Once a thoughtfulness on these matters has been engaged, conversations can be co-constructed not only to reflect upon interactional patterns but also to consider the nature of the vulnerabilities to being *bound, magnetized, or compelled* by the invitations extended in these patterns. These kinds of conversations are encouraged with the hope that such conversations relieve the vulnerabilities and create capacities to act from a clarified position—as when we clean our windshield to drive.

The *resources and constraints* available to family members that influence their capacities to withstand or to select instigations, in action, are also helpful focal issues for therapeutic discussion. In this way, the level of "attachment" one holds with respect to one's *construction of reality* can be directly addressed. The *habit* of being unable to mindfully select *non-participation* may lead to a behavioural style of pervasive unconscious avoidance of human contact. This pattern has been adopted by one young adolescent undertaking FT treatment. He has used this pattern so extensively that he has developed little capacity to process

useful life-supporting information, as he apparently contextualizes his experience by *seeing* an overriding requirement that he escape an eternal judgmental "gaze." In this case, some therapeutic success has been attained by sharing with him, the story of Narcissus and talking about how Narcissus could have potentially envisioned more possibilities in life. Also, good results came from an ongoing consideration about Narcissus's vulnerability to the "winds" of the external world, as to the quality of his *reflection* and his knowledge about himself, as well as his knowledge about others. From these dialogues, the young man in FT has been able to begin the process of *seeing* some of his own behavioural mechanisms and *considering* other sorts of approaches that he can undertake in relation to the challenges he has found himself needing to face.

One other self-proclaimed *narcissist* realized this orientation through a circumstance that was deeply painful and which eventually forced another kind of attention. The pattern here had begun with the family of origin. In this situation, an aggrandizing relative who encouraged the experience of superiority helped emphasize a constricted view of *reality* for the client. Once the narcissistic orientation was recognized, the "enactor" of this pattern was easily enabled to move toward an attitude of mutuality and egalitarianism.

The third situation that may seem an anomaly, but may occur quite frequently, is one where a very positive and indulgent orientation occurs in early childhood. Subsequently, a reversal of these affairs, in the "wake" of a major family

crisis, significantly depletes the family's emotional and physical resources so that the original indulgent orientation is reversed. This was the case for one client defined by her family as "self-centered" but who showed pain in the confusion of oscillating between an identity with superiority and one with inferiority. In this case, the person had been a youngest child of several siblings but the father died when the child was eight. Therefore, *both* extremes of "type" of input had occurred and helping this person access *news of difference* involved noticing the *oscillation* between identities rather than being given explicit information about one identity or another.

The purpose of drawing attention to the story of Narcissus is *not* to take a step backward towards a "labelling" practise but to enrich the therapeutic possibilities by explicitly acknowledging the effects of over-identification with external invitations and by encouraging family therapists to address the problem of how this *bondage* can be overcome.

The one-pointed endeavor to take in more of one's reflection from the external world has the most profound consequence in the loss of dynamism that could be accomplished through living a myriad of life's possibilities—and even not being able to realize what one has been missing. And all that others can be to such a person is merely an *echo* of one's most outer form. Yet even in this condition, there is hope for life-bearing metamorphosis, with gentleness and in time—another flower (a *Narcissus*) emerges.

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